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is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term services are needed to maintain the individual in the community.

a. Services shall be provided following an assessment which clearly documents the need for services and in accordance with an ISP which must be fully completed within 30 days of service initiation.

b. Provider of psychosocial rehabilitation must be licensed by DMHMRSAS.

c. The program must operate a minimum of two continuous hours in a 24-hour period. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day.

d. Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the client's understanding or ability to access community resources.

e. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

(1) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.

(2) Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized.

(3) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.

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(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

3. Admission to crisis intervention services is indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. Crisis intervention may be the initial contact with a client.

a. The provider of crisis intervention services must be licensed as an Outpatient Program by DMHMRSAS.

b. Client-related activities provided in association with a face-to-face contact are reimbursable.

c. An Individual Service Plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

d. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP must be developed or revised to reflect the short-term counseling goals by the fourth face-to-face contact.

e. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

f. Crisis intervention services may be provided to eligible individuals outside of the clinic and billed, provided the provision of out-of-clinic services is clinically/programmatically appropriate. Travel by staff to provide out-of-clinic services is not reimbursable. Crisis intervention may involve contacts with the family or significant others.

4. Case management.

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a. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

b. The Medicaid eligible individual shall meet the DMHMRSAS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

c. There shall be no maximum service limits for case management services.

d. The ISP must document the need for case management and be fully completed within 30 days of initiation of the service, and the case manager must review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

e. The ISP must be updated at least annually.

5. Intensive community treatment (ICT) for adults.

a. An assessment which documents eligibility and need for this service shall be completed prior to the initiation of services. This assessment must be maintained in the individual's records.

b. A service plan must be initiated at the time of admission and must be fully developed within 30 days of the initiation of services.

6. Crisis stabilization services.

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a. This service must be authorized following a face-to-face assessment by a QMHP. This assessment must be reviewed and approved by a licensed mental health professional within 72 hours.

b. The assessment documents the need for service and anticipated duration of need.

c. The Individual Service Plan (ISP) is developed or revised within 24 hours of assessment or re-assessment.

d. Room and board, custodial care, and general supervision are not components of this service.

e. Clinic option services are not billable at the same time as crisis stabilization services.

f. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hosptialization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experiencing difficulty in maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.

(2) Experiencing difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jepardized;

(3) Exhibiting such inappropriate behavior that immediate interventions by mental health and other agencies are necessary; or

(4) Exhibiting difficulty in cognitive ability such that the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior.

7. Mental health support services.

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a. The individual receiving MH support services must have an active case management plan in effect which includes monitoring and assessment of the provision of MH support services. The individual responsible for the case management plan and for the provision of case management services shall not be the provider of MH support services nor the immediate supervisor of the staff person providing MH support services.

b. There shall be a documented assessment/evaluation prior to the initiation or re-authorization of services. The assessment/evaluation must have been completed by a QMHP no more than 30 days prior to the initiation or re-authorization of services.

c. The ISP must be developed within 30 days of the initiation of services and must indicate the specific supports and services to be provided and the goals and objectives to be accomplished.

d. The ISP must be reviewed every three months, modified as appropriate, and must be updated and rewritten at least annually.

e. Only direct face-to-face contacts and services to individuals shall be reimbursable.

f. Any services provided to the client which are strictly academic in nature shall not be reimbursable. These include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.

g. Any services provided to clients which are strictly vocational in nature shall not be reimbursable. However, support activities and activities directly related to assisting a client to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be reimbursable.

h. Room and board, custodial care, and general supervision are not components of this service.

i. This service is not reimbursable for individuals who reside in any domiciliary care facilities such as ACRs or group homes or nursing facilities where staff are expected to provide such services.

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j. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

(1) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community;

(2) Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.

(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

12 VAC 30-60-145.

D. Mental retardation. Utilization reviews shall include determinations that providers meet all the requirements of Virginia state regulations found at VR 460-03-3.1100.

Appropriate use of case management services for persons with mental retardation requires the following conditions to be met:

1. The individual must require case management as documented on the consumer service plan of care which is developed based on appropriate assessment and supporting data. Authorization for case management services shall be initially obtained from DMHMRSAS staff.

2. An active client shall be defined as an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and other entities including a minimum

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of one face-to-face contact within a 90-day period.

3. The plan of care shall address the individual's needs in all life areas with consideration of the individual's age, primary disability, level of functioning and other relevant factors.

(a) The plan of care shall be reviewed by the case manager every three months to ensure the identified needs are met and the required services are provided. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be given up to the last day of the fourth month following the month of the prior review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of the actual review.

(b) The need for case management services shall be assessed and justified through the development of an annual consumer service plan.

4. The individual's record must contain adequate documentation concerning progress or lack thereof in meeting the consumer service plan goals.

12 VAC 30-60-147. E. Substance abuse treatment services utilization review criteria. Utilization reviews shall include a determination that providers meet all the requirements of Virginia state regulations found at 12 VAC 30-130-540 through 12 VAC 30-130-590.

1. Substance abuse residential treatment services for pregnant and postpartum women. This subdivision provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.

a. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12 VAC 30-130-540 through 12 VAC 30-130-590.

(1) To assess whether or not the woman will benefit from the treatment

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provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) as described in *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition*, as amended, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III. 5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in *Patient Placement criteria for the Treatment of Substance-Related Disorders, Second Edition*, as amended, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the above professionals shall demonstrate competencies in the use of these criteria. The authorizing professional shall not be the same individual providing nonmedical clinical supervision in the program.

(2) Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

(3) Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.

(4) The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

(5) The ISP shall be reviewed and updated every two weeks.

(6) Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

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(7) Face-to-face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.

(8) While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other Community Mental Health/Mental Retardation/Substance Abuse rehabilitative services concurrently rendered to her.

(9) Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

b. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:

(1) The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine (BOM) of the Virginia Department of Health Professions (DHP). The contract must include a provision for medical supervision of the nurse case manager.

(2) The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24 hour access to services for the woman, and ongoing training and consultation to the staff of the program.

(3) In addition, the provider must provide access to the following services either through staff at the residential program or through contract:

(a) Psychiatric assessments, as needed, which must be performed by a physician licensed to practice by the Virginia BOM.

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(b) Psychological assessments, as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology (BOP) of Virginia DHP.

(c) Medication management, as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the BOM in consultation with the high-risk pregnancy unit, if appropriate.

(d) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the BOP of Virginia DHP.

(e) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid sponsored primary health care program).

c. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

(1) The provider of treatment services shall be licensed by DMHMRSAS to provide residential substance abuse services.

(2) Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(i) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a Substance Abuse Counselor by the Board of Professional Counselors, Marriage & Family Therapists (BPCMFT) of the Virginia DHP, or as a Certified Addictions Counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors;

(ii) A professional licensed by the appropriate board of Virginia DHP as either a professional counselor, clinical social